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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/25/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: OP right shoulder scope, AC joint resection, subacromial decompression

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for OP right shoulder scope, AC joint resection, subacromial decompression is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his right shoulder when he slipped on some ice. The x-ray of the right shoulder dated 12/10/13 revealed discernible calcification that was dystrophic in nature. This was identified in the vicinity of the distal rotator cuff and the humeral tuberosity. Moderately severe degenerative changes were also present at the acromioclavicular joint including a subchondral cyst formation within the distal clavicle. A small degenerative cyst was present at the humeral head in the vicinity of the greater tuberosity. The MRI of the right shoulder dated 01/07/14 revealed a supraspinatus and infraspinatus tear. Right shoulder joint effusion was also identified. Subacromial fluid collection was also present. Hypertrophic changes were identified at the right acromioclavicular joint along with fluid. The clinical note dated 01/28/14 indicates the patient complaining of right shoulder pain. There is an indication that the patient is showing hypertensive readings with a blood pressure of 160/108 at that time. The note indicates the patient will be rechecked. The patient is recommended for a rotator cuff repair along with a subacromial decompression and spur removal. The patient was also identified as having significant labral tearing at the anterior aspect of the shoulder. The note further mentions the patient having a tear in the biceps tendon which was subluxing within the joint. The patient stated that he was unable to provide any range of motion throughout the right shoulder and was unable to get to neutral in internal or external rotation, flexion or extension, as well as abduction.

The utilization review dated 01/27/14 resulted in a denial as no information was submitted confirming the patient's exhaustion of all conservative treatments.

The utilization review dated 02/10/14 resulted in a denial as no information was submitted regarding the patient's completion of any conservative treatments.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of right shoulder pain with associated range of motion deficits. The MRI of the right shoulder dated 01/07/14 revealed a supraspinatus and infraspinatus tendon tear as well as an additional tear at the infraspinatus muscle. However, the subscapularis and teres minor tendons are confirmed to be intact. The glenoid labrum was also identified as being intact. The biceps tendon was also identified as being intact. Therefore, it does not appear that a full thickness tear has been identified. Additionally, a subacromial decompression would be indicated following a full course of conservative therapy. No information was submitted regarding the patient's previous involvement with any therapeutic interventions. Additionally, no information was submitted regarding the patient's previous injections at the right shoulder. As such it is the opinion of this reviewer that the request for OP right shoulder scope, AC joint resection, subacromial decompression is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)